ALABAMA DERMATOLOGY ASSOCIATES
MEDICAL | SURGICAL | COSMETIC

PATIENT INFORMATION

Date: _____

Please Print

Complete Name: _____ Birthdate: _____
First Middle Last Month Day Year

Mailing Address: _____ SS#: _____
Street City State Zip

Email: _____ Place of Employment: _____

Telephone #'s (including area code): _____
Home Cell Other

Which should we call first? ☐ Home ☐ Cell ☐ Other May we leave a voicemail or text message? ☐ Yes ☐ No

(If Student) Home Address: _____ City: _____ State: ____ Zip: _____

Person Responsible for Bill: _____ Relation to Patient: _____

Mailing Address of Person Responsible: _____

Place of Employment of Person Responsible: _____

Primary Care Physician: _____ Referring Physician: _____

Gender: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed or Widower
Ancestry: ☐ African ☐ Asian ☐ White ☐ Other: _____ Are you Hispanic or Latino? ☐ Yes ☐ No
Preferred Language: ☐ English ☐ Spanish ☐ Other: _____
Pharmacy Name, Street and City: _____

Medical History: *(Please list all your medical problems or conditions)*

_____
_____
_____
_____
_____
_____
_____
_____
_____

Surgeries: _____
_____
_____
_____

Skin Disease(s): _____
_____
_____

Do you wear sunscreen? ☐ Yes ☐ No ☐ SPF? ____
Do you tan in a tanning bed? ☐ Yes ☐ No
Do you have a family history of melanoma?
☐ Yes ☐ No Which relative? _____

Current Medications: *(including vitamins, supplements, herbals, over-the-counter, aspirin, and those for skin conditions)*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have any MEDICATION ALLERGIES?
☐ **YES** ☐ **NO** If yes, please list: _____
_____

Alcohol? ☐ None ☐ Less than 1 drink/day
☐ 1-2 drinks/day ☐ 3 or more drinks/day

Tobacco? ☐ Current every day smoker
☐ Current some day smoker ☐ Former smoker
☐ Never smoker